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ABSTRACT

The clinical research literature exploring the efficacy of particular treatment approaches is reviewed with the intent to facilitate the training of counseling students. Empirically supported treatments (ESTs) is defined operationally as evidence-based treatments following the listing of empirically validated psychological treatments reported by the American Psychological Association. Using treatment guidelines in therapy, and the problems associated with using ESTs in managed care psychotherapy (where not all guides are consistent) are discussed. Research and treatment are summarized for the following diagnostic categories of parenting problems: thumbsucking, nailbiting, encopresis (fecal soiling), enuresis (incontinence), aggression in boys, childhood oppositional disorder, and psychosomatic illnesses in children. Each topic includes a discussion of the disorder or problem with its negative consequences, a brief overview of the most pertinent research on it, and a comprehensive outline of the treatment approach. (Contains 113 empirically supported treatments). (EMK)

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ED 420 015

Familiarizing Students with the Empirically Supported Treatment Approaches for Childhood Problems

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In training counseling students, it is increasingly important to acquaint them with the clinical research literature exploring the efficacy of particular treatments. This review of empirically supported treatments (ESTs) is intended to facilitate this educational process. ESTs, or evidence based treatments, are based on studies recommended by Division 12 of the American Psychological Association in their report on empirically validated psychological treatments (Chambless et al., 1996; Task Force on Promotion and Dissemination of Psychological Procedure, 1995). The original listing was recently expanded to include 57 treatments that had withstood the test of careful empirical scrutiny (Chambless & Hollon, 1998). Developing specific psychotherapeutic techniques for homogeneous populations is a current focus of psychotherapy research (Orlinsky & Howard, 1986).

To qualify for inclusion in the EST listing, for each treatment research must have shown that it leads to a reduction or remission of the disorder or problem at a rate higher than occurs with the passage of time (efficacious) or that it outperforms an alternative active treatment (efficacious and

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specific). Knowledge that a treatment has been shown to be efficacious should affect decisions about how one practices psychotherapy.

Using Treatment Guidelines

Clinical practice guidelines based on laboratory research, outcome data, and cost containment needs are becoming increasingly common. Their use raises several serious practical and ethical questions. How can guidelines be customized to meet the specific needs of particular clients? How can we tailor treatments without compromising their established efficacy? How can clinicians preserve their own creativity and spontaneity while adhering to treatment guidelines? How can clinicians stay attuned to the idiosyncracies of individual cases while employing treatment protocols? How can clinicians avoid becoming distracted and myopic in using treatment guidelines? How can clinicians accommodate the need to provide "partial" treatment?

While the guidance offered by these treatment literatures is invaluable, it is not enough simply to memorize a treatment protocol or manual and deliver it when we meet someone with the appropriate diagnosis. The need to customize the ESTS in light of individual learning styles and preferences, the existence of codiagnoses, and other mediating variables, will help to keep psychotherapy part "art" for some time to come!

Using ESTS in Making Managed Care Psychotherapy Work

Managed care providers are expected to adhere to treatment guidelines described in manuals provided by individual managed care companies. One of the frustrations associated with doing managed care work involves the lack of uniformity that exists across these guides. While all are derived from a common research literature on treatment efficacy, companies have worked independently to craft distinctive guidelines, which are considered proprietary. This restricts free and widespread access to this information, and has stymied development of consensual "industry standard" guidelines.

Although initially you may feel baffled by the need to comply with disparate instructions about how to proceed with clients carrying a particular diagnosis, as you review the different manuals, you will notice considerable overlap. To simplify your clinical work, you may wish to focus on mastering the conclusions from the empirical treatment literature. This body of research forms the basis for all the separate clinical manuals managed care companies have developed. If you can provide a case reviewer with the research basis for your treatment plan and process, minor deviations from the specific guidelines will generally be accommodated.

The following sections organize the treatment efficacy literature according to diagnostic category. Dually diagnosed clients will require some creative merging of techniques, unless

their particular combination of problems has been specifically addressed in the literature.

Studies selected for summary were taken from the national listing of Empirically Validated Treatments developed by the American Psychological Association. The criteria for inclusion in the APA sample is described in detail elsewhere, but priority was given to carefully controlled, double-blind, randomized studies with adequate sample size and measures to assure high treatment fidelity.

Most of the controlled studies of psychological treatments have been conducted on behavioral or cognitive approaches, although recently there has been increased use of clinical trials methodologies in tests of other treatment approaches, such as those based on psychodynamic theory.

Summaries of Research on ESTs for PARENTING PROBLEMS

Thumbsucking

Thumbsucking is often considered offensive aesthetically, and it has been shown to be associated with dental problems, particularly for children older than three years of age (Wright, Schaefer and Solomons, 1979). Thumbsucking is found in 46% of 3-year-olds, and 37% of 4-year-olds (Honzik and McKee, 1962). A survey found 22% of children to still suck their thumbs at age 12 (Baalack and Frisk, 1971).

The operant habit reversal method of treatment consists of teaching competing responses, identifying the habit prone situation(s), arranging social support by the family, providing a response contingent period of competing reactions, and identification of response precursors. This method was compared with the commonly used method of painting the thumb and fingers with a bitter tasting substance in a study by Azrin, Nunn, and Frantz-Renshaw (1980). Children receiving habit reversal treatment had a mean reduction of 88% on the first day, 95% thereafter until the twentieth month when the reduction was 89%. This was far better than children in the bitter tasting substance control group, who showed only a 34-44% reduction during the 3 months of follow-up.

Habit reversal children had a mean of 1.8 episodes per day, whereas control group children had a mean of 21.2 episodes per day. At the 3-month follow-=up, 47% of the habit reversal treatment children had stopped thumbsucking completely and all of the others had a reduction of at least 50%. Of the control children, only 10% had stopped sucking entirely, and 60% showed little or no change (less than a 50% reduction).

The habit reversal method has been found to be nearly as effective as the palatal or crib with spurs (Haryett, Hansen, & Davidson, 1970), without causing the emotional, eating, and speaking problems frequently associated with the crib method of treatment. The magnitude of the reduction associated with the habit reversal method is substantial and immediate.

Azrin, N. H., Nunn, R. G., & Frantz-Renshaw, S. (1980b). Habit reversal treatment of thumbsucking. Behaviour Research and Therapy, 18, 395-399.

Azrin, Nunn, and Frantz-Renshaw (1980) reported a first day mean reduction of sucking of 88%, which progressed to a 98% reduction at their 5-month follow-up. Given the absence of the problematic side effects linked to other professional methods of treatment, the demonstrated efficacy of the habit reversal method seems to make it the general treatment of choice for this problem.

Treatment Method

Counseling occurs in a single session of 1-2 hours duration, the first portion of which is spent teaching the child what to do. In the second part of the session, the child describes the program to the parent and requests the parent's assistance.

During an "annoyance review", the child lists all the problems created by the thumbsucking. In the "heightened awareness" procedure, the child acts out the usual response sequence, especially the precursors of the thumbsucking so as to identify the stimulus antecedents of the behavior (Azrin, Nunn, & Frantz-Renshaw, 1980). The treatment steps are presented as a game involving clenching and gripping exercises that are the responsibility of the child. Parents are asked to provide helpful reminders and encouragement. The child is taught competing reactions, such as making a fist in which the thumb grips the fingers if the child is a fingersucker or the fingers grip the thumb if the child is a thumbsucker, or the child grasps some convenient object. The competing responses are rehearsed until performed correctly. The gripping-clenching response is to be maintained for about 1-3 minutes. The child times the duration by counting aloud slowly to 100 (younger children can count to 10 several times). The competing response serves as a preventive measure in the identified habit prone situations and as a corrective measure when thumbsucking or any face touching occurs.

Social support is encouraged by asking parents to praise their child when sucking is absent and by providing pleasant surprises, visits, etc. when sucking is absent for an extended time period. Parents are instructed to turn off the television or interrupt the suggested bedtime story when sucking occurs. Children identify a concerned person (e.g., neighbor or grandparent) to call to report on their progress.

Nailbiting

Nailbiting is a common nervous habit. The disorder, which includes both nailbiting and nailpicking, produces several types of deformations, including cuticle damage, roughness of the nail

edge, shortened nails, and skin damage. People often want to stop biting their nails for a variety reasons (Coleman & McCalley, 1948; Billig, 1941). For instance, some people want to improve the appearance of their nails. Others may want to stop the embarrassment associated with their habit.

Previous treatments for nail biting have included shock aversion (Bucher, 1968), negative practice (Smith, 1957), the use of a bitter substance (Billig, 1941), covert sensitization (Paquin, 1977), self-recording (Horan, Hoffman, & Marci, 1974), and habit reversal (Azrin & Nunn, 1973). Studies comparing the effectiveness of different behavioral treatments using control group designs have found no differential effectiveness. These studies have generally concluded that the expectations of treatment benefits and heightened awareness are sufficient in reducing nailbiting. Efficacy evaluations have made use of different measures, such as the clinical rating of appearance of nails, cuticles, and skin (Malone & Massler, 1952; Billing, 1941), length of nails (Vargas & Adesso, 1976), and the number of nailbiting episodes (Delparto et al., 1977; Bucher, 1968).

Azrin, N. H., Nunn, R. G., & Frantz, S. E. (1980a). Habit reversal vs. negative practice treatment of nailbiting. Behaviour Research and Therapy, 18, 281-285.

Azrin, Nunn, and Frantz (1980) attempted to evaluate if the habit reversal method reduced nail biting more than negative practice when self-recording, heightened awareness, and expectation of benefits were assessed. Habit reversal includes awareness training as well as practice periods. Azrin et al (1980) used ninety seven subjects, all of whom responded to an advertisement in the newspaper. Placement in a group was determined by a coin flip; forty five subjects were placed in the habit reversal group and fifty two subjects were placed in the negative practice group.

Habit Reversal

The first session of habit reversal was two hours long and involved two groups of people who bit their nails. The second session was devoted exclusively to nail inspection and discussion. Clients were paired and practiced alternative behaviors with one another under the counselor's supervision. The nailbiters learned to engage in a competing hand grasping reaction for three minutes whenever the nailbiting occurred. Positive nail care, including nail filing and the use of hand lotion, was emphasized. All nailbiting episodes and hand-to-face movements were followed by the grasping reaction and positive nail care activities. Subjects were made to practice biting their nails in front of their therapist or partner to facilitate identification of the response. Subjects were taught to identify situational, social, and postural precursors in order to be able to anticipate the behavior. During the first two weeks after the

sessions, follow up calls were made every few days. Following that, calls were made every two weeks for several months.

Negative Practice

Negative practice was administered in a two hour session, in which subjects met in groups. During the session, patients simulated nailbiting in front of one another while telling themselves how ridiculous they looked. The counselor described the rationale of the treatment, answered questions, and supervised the patients' practice. Patients were given written instructions, which were provided by Smith (1957). In addition to these instructions, patients were given recording charts. Patients had to practice the exercises for thirty seconds every hour following the treatment session. Once the nailbiting and/or nailpicking had been eliminated, patients had to continue the exercise for four days. Over a period of two weeks, the exercise was gradually decreased. Before an inspection meeting, subjects were contacted according to the same schedule as subjects in the habit reversal group.

Azrin et al (198) found the habit reversal method to be more effective than the negative practice method in reducing the frequency of nailbiting (Azrin, 1980). Forty percent of habit reversal subjects stopped biting their nails entirely, where as only fifteen percent of the negative practice subjects stopped biting their nails. Negative practice was found to reduce nailbiting episodes by up to sixty percent. On the other hand, habit reversal was found to reduce nailbiting and/or nailpicking episodes by ninety nine percent.

Encopresis

Wright and Walker (1978) conducted a controlled outcome study of a simple behavioral treatment program for psychogenic encopresis, and found the approach to be 100% effective when adhered to carefully. Encopresis or fecal soiling of the clothes is a frequent complain to parents. Since, organic factors, including disease or dietary practices resulting in diarrhea, or obstruction and neurological disorders resulting in impaction and organic megacolon, account for many cases, ruling out such sources of this problem prior to initiating psychological treatment is important. In a large number of cases presenting with fecal impaction accompanied by soiling, no organic condition exists; these are referred to as cases of functional or psychogenic encopresis.

The principles of operant conditioning are extremely effective in eliminating this problem. The systematic approach employed by Wright & Walker at the University of Oklahoma Medical School in over 100 cases usually takes for months to complete, but typically requires the treating psychologist or physician to have only minimal involvement after the first session.

Treatment Steps

First, a careful physical examination must be conducted in order to rule out the possibility of an organic etiology of the problem. Next, an interview with the parents and child is conducted to rule out the possibility of serious psychopathology or emotional disturbance; psychological testing may be necessary in ambiguous cases.

The parents are instructed in the details of the program. The parents are the ones responsible for explaining the program to their child, except in cases where the professional believes that the parents would have difficulty in so doing.

To begin the program, the child's colon should be evacuated; an enema the night before the program begins is usually sufficient. The child should go to the bathroom immediately upon awakening in the morning. The parents supervise this, and offer praise and a reward (agreed upon in advance) as an incentive for the child's trying.

If the child does not produce a reasonable amount of feces on his own, the parent inserts a glycerine suppository and permits the child to dress, have breakfast, and prepare to leave for school. After breakfast, the suppository generally will have had its effect; the parent returns the child to the bathroom to defecate before school. The child receives a smaller reward for succeeding this second time.

If shortly before it is time to leave the child has not yet defecated, the parent then administers an enema. The enema used should be a method safe for repeated administration and that side effects be watched and controlled for. In most cases, the child will be able to evacuate on his own, making repeated administrations of suppositories and enemas unnecessary. Where prolonged use is required, the schedule of administration is lengthened to one every other day or one every third day. Essentially, defecation must occur every morning during the program. While it is not physically necessary for a person to defecate daily, during this training the child is learning how to regularize his bowel habits, and daily practice is helpful. At the end of the day, the child's clothing is examined at a specified time, usually shortly before bedtime. If there is no soiling, the child receives a small reward. If there is soiling, the child receives a mild punishment.

Choice of both rewards and punishments should occur prior to initiating the program, and requires considerable individualization. Among the rewards that have been found to be effective are such things as money, candy, small toys, praise, extra privileges, tickets to recreational events, movie rentals, etc. A generally effective reward involves allotting children a certain period of time (20 minutes or so) in which their parents will do anything they ask, such as playing games, reading a book, talking, or giving a piggy-back ride. This provides children with a socially acceptable way of controlling their environment, which can help to supplant the previous maladaptive strategy. Restriction of television viewing, loss of privileges, monetary

fines, and extra chores (especially chores of siblings) have proven to be effective punishments. Having the child sit in a chair for a set period of time is a generally effective punishment.

A typical program might involve giving 50 cents if the child defecates on his own in the morning, 25 cents if a suppository is required, and 20 minutes of parental time and attention if no soiling occurred. If soiling occurred, the child would sit in a chair for 15 minutes.

The regime described above is continued without interruption. Parents must be encouraged to be entirely consistent in carrying out this program, even when visitors or vacations threaten to disrupt the daily routine. The parents are asked to keep a daily notebook, treating the experience the way they would an experiment in the lab, recording events, times, and outcomes. It is often helpful to inform parents that when properly conducted, this treatment virtually never fails (Wright & Walker, 1978). These notes, along with information about how the child seems to be feeling and doing on the program, care mailed to the therapist's office at the end of each week. The therapist makes a phone contact with the parents each week, generally after receipt of the notes. This permits efficient provision of encouragement, support, and any necessary advice.

After two consecutive weeks in which no soiling has taken place, it is time to begin phasing out the program. Cathartics are eliminated one selected day of the week. The remainder of the program continues as before. If no soiling occurs for another week, a second "no cathartic" day is added (e.g., Monday and Thursday). This continues until the child is free of soiling and no longer makes use of cathartics. At this point, the reward and punishment system is terminated.

If soiling recurs, the procedure is to retreat one step and start over again. this program generally eliminates the encopretic problem in 15 to 20 weeks. Most children spontaneously begin to show improvement in other areas of their lives, seeming happier, more self-confident, more competent at school, and showing better response to discipline. This treatment takes approximately 30 minutes of the therapist's time at the initial parent-training session, and a few minutes each week to supervise the family's conduct of the program.

Enuresis

Enuresis has been defined as the "involuntary passage of urine" (Hinsie & Campbell, 1970). It can be categorized as one of two types: primary or secondary. Primary enuresis has been defined as involuntary discharge of urine when bladder control has not yet been achieved (Copeland, 1982; Doleys, 1977; Lovibond,1970). Other researchers have defined primary enuresis as a lack of urinary continence for any one-year period regardless of whether continence has been achieved in the past (American Psychiatric Association, 1980). Secondary enuresis is

defined as involuntary urination only after achievement of continence (American Psychiatric Association, 1980; Doleys, 1977; Lovibond, 1970). The subclassification of diurnal or nocturnal enuresis resulted when researchers considered the time in which enuresis occurs. Involuntary discharge of urine during the day without underlying organic cause and after expected continence, has been labeled diurnal enuresis. Nocturnal enuresis has been defined as the involuntary discharge of urine during sleep, without underlying organic cause, and after continence may have been expected (American Psychiatric Association, 1980; Copeland, 1982; Lovibond, 1970). Research has found that 90% of enurectic children are of the nocturnal variety (Copeland, 1982). Kupfersmid (1989) conducted a study examining several different treatment avenues for nocturnal enuresis. When organic factors have been ruled out for the cause of the enuresis, three major treatment regimens have been recommended: psychotherapy, medication, and behavior modification.

Treatment Techniques

The use of psychotherapy as a treatment of enuresis has been questioned by researchers. There has been little agreement among psychoanalysts regarding the psychodynamic causes of enuresis (Hinsie, 1970; Johnson, 1983; Mower, 1938). Studies have not demonstrated an association between enuresis as a behavior and specific psychiatric symptoms, nor have studies yielded evidence that disturbed subjects are less responsive than controls to conditioning treatments. Psychoanalysts believe that enuresis is a result of an unconscious conflict and that if the enuretic episodes are eliminated without resolution of the underlying conflict another symptom will be substituted. However, cure rates for psychotherapy treated subjects have been no higher than waiting list controls (DeLeon, 1966; Werry, 1965) Therefore, psychotherapy is not recommended for the treatment of enuresis on the basis of lack of empirical demonstration, financial cost to clients and time expenditures for both therapist and patient.

A variety of medications are used in the treatment of enuresis with equivocal results (Blackwell, 1973; Freeman, 1975; Lovibond 1970). The most common family of drugs used are tricyclic antidepressants namely imipramine. An overwhelming majority of studies having utilized imipramine with children have reported statistically significant results when compared with placebo controls in double blind studies, however the reported cure rates in these studies was only 10 to 20%. Usually the effects of imipramine occur within the first week of administration, however subjects tend to relapse immediately after drug withdrawal (Blackwell, 1973; Johnson, 1983). Results of follow up studies have shown that the results of imipramine use show no higher success rates than the rate of spontaneous remission. AS for the effectiveness of other medications including stimulants, monoamine oxidase inhibitors,

sedatives-hypnotics, major tranquilizers, anticonvulsants, diuretics and anticholinergics, results have provided little evidence to their effectiveness (Blackwell, 1973; Pierce, 1975). Further research is required to determine the role of medication in the treatment of this disorder. Drug combinations and dosages need to be examined to determine which combinations work best together. Drug therapy and behavioral modification also needs to be examined to determine its effectiveness.

There are several different behavioral conditioning approaches used for the treatment of enuresis. One such technique is the pad and buzzer. This technique was first reported by Mower and Mower (1938). The apparatus was designed such that urine acts as an electrical conductor between two electrodes resulting in an auditory stimulus (buzzer). There have been several modifications of this technique since it introduction with variations of effectiveness. There have been several literature reviews assessing the effectiveness of the pad and buzzer. These reviews have consistently reported that 80 to 90% of subjects reach an initial criterion of 7 to 14 consecutive dry days within 4 to 6 weeks of treatment (Dische, 1973; Doleys, 1977; Lovibond 1970; Turner, 1973). Relapses have been reported to occur in 25 to 40% of those successfully treated however of those who relapse two thirds have successfully been reconditioned (Doleys, 1977; Turner, 1973). Two behavioral techniques have been developed to reduce relapse. They are retention control training (RCT) and overlearning. RCT was designed to increase a child's bladder capacity thus mitigating the need for urination during sleep. This technique involved the child gradually increasing the intake of liquids and withholding voiding as long s possible. Overlearning involves having a child drink a specified amount of liquid prior to bedtime.

Another behavioral treatment of enuresis is Dry Bed Training (DBT). DBT is an attempt of achiever higher treatment success, with reduction in the rate of relapse, and greater parental cooperation. It is an intensive procedure that involves the use of an alarm, the parent awakening the child at set times and positive reinforcements for dry nights. Modification of this technique were also tried but they were not as effective as the DBT with the pad and buzzer.

The role of parents in the treatment of enuresis is an important factor to consider. Studies have found that 18% of enuretic children's parents have failed to follow through when referred for treatment (Young, 1972b) and that 27% of parents terminate treatment prematurely (Young, 1972a). Doleys (1977) has maintained that the one most common reason for treatment failure has been lack of parental cooperation.

Of all the techniques the pad and buzzer has proven to be the most effective treatment of nocturnal enuresis. The success of this treatment is one of the most well documented techniques in psychology. Although relapses may still occur with this treatment, reconditioning works well and can lead to continued success. There are a few problems with the pad and buzzer such

as false alarms due to perspiration and or the pad slipping and failure of the alarm to arouse the child. The loudness of the buzzer is an uncontrolled variable that may have affected outcomes across studies. Another confound could be the degree of parental support. In the future, the degree of compliance with treatment needs to be more accurately assessed.

Aggressive Boys

Walter, H. I., & Gilmore, S. K. (1973). Placebo versus social learning effects in parent training procedures designed to alter the behavior of aggressive boys. Behavior Therapy, 4, 361-377.

The purpose of Walter and Gilmore's study was to evaluate a set of previously assembled and proven behavior modification techniques and to compare the effects of these techniques to a placebo treatment emphasizing status attention and expectancy features inherent in the procedures. The use of direct family observation as a measurement of change provided a clear criterion for comparison of treatment techniques. The present study had two objectives: (1) to replicate the Wiltz (1969) study concerning parent's learning to decelerate significantly rates of targeted deviant behaviors in a 10-week span of time by engaging in the Patterson et al. (1972) training procedures; (2) to compare the effects of these training procedures to a placebo treatment emphasizing status attention and expectancy features inherent in the procedures.

Subjects consisted of 12 families referred to the Social Learning Project, Oregon Research Institute, between January and September 1970. The identified deviant child was a male between the ages of 5 and 14 who was exhibiting severe "out of control" behavior as characterized by some or all of the following: fighting, lying, noncompliance, stealing, fire-setting, temper tantrums, destructiveness, and negativism. The second major purpose of this study demanded controlling factors known to influence treatment efficacy, such as therapist's warmth and friendliness, in order to assess more accurately the specific effects of training parents to use behavior modification principles. From the initial intake procedure to the final intervention observation, every effort was made to provide the same degree of status attention, encouragement, and therapist's optimism concerning treatment effectiveness to all parents.

The first three families selected were assigned to the treatment condition; the next three to the placebo condition. The procedures for the treatment group parents were those routinely employed with families of conduct-disordered boys (Patterson et al., 1972). Following six baseline observation sessions, the parents in the treatment condition were given the programmed text Living with Children (Patterson & Gullion, 1968). Parents were taught specification and collection of data

pertaining to particular aspects of their children's behavior. Daily telephone contact with the parents provided assistance with any difficulties regarding their learning to collect data. They attended a weekly structured parent group session in which each couple received 30 min to construct programs for targeted deviant behaviors. At least two experienced therapist were present, and at their discretion, utilized role-playing, modeling, and didactic instruction to teach the principles of behavior management. After 4 weeks of group meetings, intervention observations were carried out.

The placebo group condition consisted of all the above procedures, but with no programmed text and no therapist present at group meetings. To duplicate the time and attention of the book reading period, placebo group parents were given tape recorders and invited to practice making recordings about their problems for the upcoming meetings. As in the treatment condition, placebo families were telephoned regularly to stimulate cooperation and to answer questions.

Change in Targeted Deviant Behavior

It was expected that targeted deviant behaviors in the identified child would decrease in the treatment group and show no change in the placebo condition. The mean baseline rate of .161 for the treatment group compared to their fourth-week intervention rate of .062 represented a 61% decrease in targeted deviant behavior, is comparable to the decrease in the Wiltz (1969) treatment group (see Walter, 1971). The mean baseline rate of .253 for the placebo group compared to their fourth-week intervention rate of .321 represents a 37% increase in targeted deviant behaviors. The absence of statistically significant changes in rates of targeted deviant behaviors for the placebo group is comparable to the Wiltz (1969) waiting-list control group results.

The results replicated Wiltz's (1969) earlier findings that the Patterson et al, (1972) procedures significantly reduce targeted deviant behavior during a 10- week period and clearly demonstrate that status-attention and expectancy alone are insufficient treatment vehicles for changing a child's deviant behavior. There are, however, some questions and issues posed by the current study.

Childhood Oppositional Disorder

Children who are oppositional, stubborn, noncompliant, and aggressive are frequently referred for treatment. Of all 2 to 5 year olds referred to a child mental health facility, 47% were found to display oppositional and aggressive behavior; at ages 5 to 12, 74% displayed these problems (Wolff, 1961, 1967; Wells & Forehand, 1985).

Wells, K. C., & Egan, J. (1988). Social learning and systems family therapy for childhood oppositional disorder: Comparative treatment outcome. Comprehensive Psychiatry, 29, 138-146.

Wells & Egan (1988) evaluated the comparative treatment efficacy of two treatments for childhood oppositional disorder. This carefully conducted assessment made use of multiple dependent measures, including a reliable and valid system for coding noncompliant child behavior and other parent-child interactions (Forehand, Peed, Roberts, 1978), and parent self-report inventories. Their results favored social learning-based parent training over a systems family therapy approach based on the work of Minuchin (1974) and Haley (1976).

Social Learning Parent Training

Social learning-based parent training has been widely researched. This treatment is based on the assumption that oppositional child behavior is acquired and maintained in the context of family behavior exchanges and that treatment must therefore focus on direct modification of maladaptive parent-child interaction patterns (Patterson, 1982). Numerous studies have documented the efficacy of this treatment, in terms of direct observations of parent and child behavior, parent-completed child behavior checklists, parents' satisfaction with treatment, and parents' perceptions of their own adjustment (Forehand, Wells & Griest, 1980; Karoly & Rosenthal, 1977; Patterson, Chamberlain & Reid, 1982; Peed, Roberts & Forehand, 1977; Wells & Egan, 1988; Wells, Griest & Forehand, 1980; Wiltz & Patterson, 1974).

Treatment Guidelines

Social Learning Parent Training focuses on reducing child noncompliance. In the first phase, parents learn to be more effective reinforcing agents by increasing the frequency and range of social rewards and by reducing the frequency of competing verbal behavior such as commands, questions, and criticisms. Parents learn to use social attention and rewards contingent upon appropriate child behavior, particularly compliance with parental commands. In the second phase of treatment, parents learn to give direct, concise, age-appropriate commands and expectations to their children and to allow them sufficient time to comply. If compliance is not forthcoming, parents learn to implement a time-out procedure, involving placing the child in a secluded chair for five to ten minutes. Role playing by the therapist and parent and modeling of desired behaviors by the therapist help parents to learn these skills. Parents are given homework assignments to practice daily skills learned in the therapy sessions (Wells & Egan, 1988).

Diagnostically Relevant Outcomes

Observational measures

Parent Behaviors:
Rewards: verbal praise and physical rewards (hugs, pats)
Attention: verbal descriptions of child's activity
Contingent attention: attention or praise after compliance
Commands: orders or suggestions requiring compliance
Warnings: descriptions of impending negative consequences

Child Behaviors:
Compliance
Noncompliance

Self Report Measures

Maternal emotional adjustment:
Beck Depression Inventory
Spielberger State-Trait Inventory
Locke Wallace Marriage Inventory

Systems family therapy

Psychosomatic Illnesses in Children

Although systems family therapy was not found to be the preferred treatment modality in helping oppositional children (Wells & Egan, 1988), research has supported its effectiveness in treating psychosomatic disorders in children (Lask & Matthew, 1979; Liebman, Minuchin & Baker, 1974; Minuchin, Baker, & Rosman, 1975). Systems family therapy begins with the therapist observing the family process, lo%wing for evidence of enmeshed or disengaged subsystems, covert coalitions, imbalanced hierarchies, repetitive maladaptive behavior sequence, and/or use of conflict avoidance tactics. When dysfunctional family processes or structures are identified, direct and/or paradoxical strategies are implemented in to alter the process and to relabel and reframe ongoing patterns.

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